MEDICATION ADMINISTRATION FORM

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

for Youth Camps in Maryland

I. FACILITY RECEIPT AND REVIEW								
MEDICAT	ION RECE	IVED FROM				DATE		
PLAN OF ACTION RECEIVED			[]YES []N	IO []N/A	HEALTH SUPERV	ISOR NOTIFIED	[]YES	[] NO
MEDICAT	TION RECE	EIVED BY	PERSON'S SIGNATURE				DATE	
II. MEDICATION ADMINISTRATION RECORD								
Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.								
Child's Name:					Date of Birth:			
Medication Name:					Dosage:			
Route:					Time(s) to Administer:			
DATE	TE TIME DOSAGE		REACTION OBSERVED (IF ANY)		STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION		
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KEEP FOR 3 YEARS

MDH-4759 (01/2017) Page 1